BOSTON MUTURAL LIFE INSURANCE COMPANY
120 ROYALL ST, CANTON MA 02021
781-828-7000 or 1-800-669-2668

Group Life Claim

Employer's Statement

Name of Insured:_____ Group Policy No: 0024545

Is insured known by any other name: Yes __ No__ If yes, please advise:_____

Address of Insured:_____ Certificate No:_____

_____

Date Insured Last Worked:_____ **Date of Death**_____ Amount of Insurance $5000.00

Reason for leaving work: Disability__ Resignation__ Vacation__ Leave of Absence__

Retired X Lay Off__ Dismissed__ Other__

Was Insured an Employee at time of death?_____ Insured's Occupation:_____

Date Employed:_____ **Date of Birth**_____ Effective Date of Insurance_____

Was Insurance terminated prior to death?_____ If so, date of termination and reason:_____

I hereby certify that the date through which the premium for this Insured has been paid is:_____
mo-day-yr

_____
Signature of Authorized Representative

Town of Reading
Employer

16 Lowell Street **Reading,** **MA** **01867**
Street City/Town State Zip

781-942-6635
Telephone

Beneficiary's Statement (if more than one beneficiary, kindly attach an additional beneficiary statement)

Name of Beneficiary stated on Lates designation by Employer	Date of Birth	Beneficiary's Social Security No.	Relationship

Address of Beneficiary

Street City/Town State Zip

Certification-Under the penalties of perjury, I certify that the information provided on this form is true, correct and complete.

Signature of Beneficiary _____ Date_____

PLEASE BE ADVISED THAT PROCEEDS MAY BE DELIVERED THROUGH THE EMPLOYER NOTED ABOVE

Expires 3/10